Methodology

The basis for sponsor estimates is health services and supplies (HSS)[1] totals in the National Health Expenditure Accounts (NHEA). The NHEA structure includes measures of spending for sources that pay for health care services. These sources generally define an entity, usually a third party insurer that is responsible for paying the health care bill. These funding sources are broadly classified into private health insurance, out-of-pocket spending, and specific government programs such as Medicare and Medicaid. A small portion of expenditures is estimated for other private revenues— for example, philanthropic giving and revenues received by some health care providers from such non-health activities as the operation of cafeterias, gift shops and educational programs.

Behind each NHEA source-of-funding category is an individual, business, public tax or general revenue that is responsible for financing, or sponsoring, those payments. These sponsors – designated as businesses, households, governments and other private funds – provide the financial support with which health care bills are paid. The difference between source of funds and sponsor can be illustrated using private health insurance as an example. Although private health insurers (NHEA source-of-funds category) pay claims on behalf of individuals covered by health insurance policies, premiums are often paid, or sponsored, by a combination of employers (businesses, Federal government and state/local governments) and individuals (households). Household private health insurance coverage may be provided by the employer or purchased directly by individuals in the form of individually purchased policies. Although private health insurance is considered a private source of funding in National

Health Expenditures, these payments are categorized into business, household and government sponsor categories in this presentation based on who bears the underlying financial responsibility for health insurance premiums.

The accompanying crosswalk outlines the transition from National Health Expenditure source-of-funding to sponsor categories.

Crosswalk of National Health Expenditure Payers to Businesses, Households and Governments Sponsors

	Private			Governments	
	Businesses	**Households**	**Non-Patient Revenues**	**Federal**	**State and Local**
Health Services and Supplies					
Private Sources of Funds					
Out-of-pocket Payments		x			
Private Health Insurance	x	x		x	x
Industrial Inplant	x				
Other Private Revenues including Philanthropy			x		
Public Sources of Funds					
Medicare	x	x		x	x
Workers' Compensation & TDI	x			x	
Other Government Programs					
Federal [1]/				x	
State and Local [2/]					x

1/ Includes maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, Indian Health Service, and other miscellaneous general hospital and medical programs, public health activities, Department of Defense, Department of Veterans Affairs, State Children's Health Insurance Program (SCHIP) and Medicaid.

2/ Includes other public and general assistance, maternal and child health, vocational rehabilitation, public health activities, hospital subsidies, State Children's Health Insurance Program (SCHIP) and Medicaid.

For the most part, crosswalking NHEA sources of funding to sponsor is a simple task of identifying sponsor classifications that are closely related to NHEA source-of-funding categories. For example, all NHEA out-of pocket expenditures are assigned to the household sponsor category and all Federal Medicaid expenditures to the Federal

[1] HSS includes expenditures for personal health care, government public health, administrative costs of government programs and the net cost of private health insurance. For more information on definitions in NHEA, see http://www.cms.hhs.gov/NationalHealthExpendData/.

government sponsor category. In these cases, the source-of-funding category is closely aligned with the sponsor category.

For four NHEA source-of-funding categories, however, this is not the case. For private health insurance, Medicare, state/local workers' compensation and temporary disability insurance funding sources, NHEA expenditures are reclassified into one or more sponsor categories. The translation of workers' compensation and temporary disability insurance from a source-of-funding to sponsor category is the most direct of the four. Although employers finance the expenditures, workers' compensation and temporary disability programs are designated as public programs in the NHEA because public (state) laws mandate their existence. Thus, NHEA estimates workers' compensation and temporary disability expenditures are recategorized from a state/local government source-of-funding category to the business sponsor category[2].

For Medicare and private health insurance, the issues are more complex. Similar to the private health insurance (PHI) example provided previously, Medicare expenditures are financed by several sponsors: taxes imposed on employers (who may be private businesses or governments), employees (households) or self-employed individuals (businesses and households); by premiums paid by beneficiaries (households); and by Federal government general revenues (government). Treatment of Medicare and private health insurance by sponsor therefore requires NHEA source of funding expenditures to be split into three sponsor categories: businesses, governments and households.

[2] A small expenditure for workers' compensation covering Federal employees is the financial responsibility of the Federal government as an employer. In both the NHEA source of funding and sponsor presentation, workers' compensation for Federal employers is in the Federal category.

In the following sections, the methodologies used to estimate sponsor expenditures for Medicare and private health insurance are presented.

Private Health Insurance

To produce private health insurance (PHI) estimates that are the financial responsibility of businesses, households and governments, total premiums are disaggregated into employer-sponsored and individually purchased PHI premiums. Employer-sponsored health insurance premiums are defined as premiums paid by employers and/or employees through payroll deduction, whether or not the employer actually contributes to the health plan. Union health insurance plans are also considered to be employer-sponsored plans. Employer-sponsored premiums were estimated separately for private, State/local and Federal employers and employees.

The primary data source for estimating private and State/local employer contributions to employer-sponsored health insurance plans is the Medical Expenditure Panel Survey—Insurance Component (MEPS-IC) sponsored by the Agency for Health Care Research and Quality[3]. The MEPS-IC contains estimates of PHI expenditures separately for active employees and retirees of private businesses and state/local governments. Premiums paid by private business and state/local employers for active employees and retirees were estimated for 2001 using MEPS-IC data. The 2001 employer-paid premiums were estimated back to 1987 and forward to 2004 using the annual growth rate in private health insurance premiums paid by employers for active workers derived from the Employer Cost for Employee Compensation (ECEC)

[3] Agency for Healthcare Research and Quality: Data from the Medical Panel Expenditure Survey – Insurance Component, 1996-2002. Rockville, MD. January 2005. (http://www.meps.ahrq.gov/Data_Pub/IC_TOC.htm)

component of the Bureau of Labor Statistics' (BLS) National Compensation Survey[4]. The U.S. Office of Personnel Management's Office of the Actuary supplied estimates of the premium amounts paid by Federal employers on behalf of their employees and retirees. These sources were used to allocate contributions for employer-sponsored health insurance into business, Federal or State/local governments.

The 2001 estimates of private businesses' and state/local government's employer-sponsored PHI premiums paid by active employees, retirees, and former employees who are covered by the Consolidated Omnibus Budget Reconciliation Act (COBRA)[5] were also produced using MEPS-IC data. To calculate the premiums paid by active employees, retirees and COBRA enrollees from 1987 to 2000, the annual growth rate in household payments for PHI premiums from the BLS's Consumer Expenditure Survey (CE)[6] was applied to the 2001 MEPS-IC estimate. The 2002, 2003, and 2004 premiums paid by private and state/local employees and retirees was estimated using the latest CE data blended with historical trends in the relationship between employee/retiree–paid and employer-paid share of employer-sponsored health insurance. The U.S. Office of Personnel Management's Office of the Actuary also supplied data recording payments made by Federal employees and retirees for their health insurance premiums. These estimates, along with other employee contributions to PHI, are considered to be household sector payments.

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[4]U.S. Bureau of Labor Statistics: Data from the Employer Costs for Employee Contribution Survey results for 1987-2004. U.S. Department of Labor. Washington, DC. October 2005.
(http://www.stats.bls.gov/ncs/ect/home.htm)

[7] In general, COBRA requires certain employers to continue to offer former employees and their dependents health insurance coverage at a cost of 102 percent of the employer premium for a period of 18 months.

[6] U.S. Bureau of Labor Statistics: Data from the Consumer Expenditure Integrated Survey results for 1987-2003. U.S. Department of Labor. Washington, DC. October 2004.
(http://www.bls.gov/cex/home.htm)

Premiums for individually purchased PHI were estimated using CE data for 1987 to 2003 and growth from the A.M. Best survey for 2004.

Medicare

Estimates for Medicare expenditures are split into sponsor categories of businesses, households or governments. The Medicare program is financed by several different mechanisms. The Hospital Insurance (HI) trust fund is primarily financed through Federal Insurance Contributions Act (FICA) taxes on covered payroll, plus interest, taxation of benefits[7] and other revenues.[8] The Supplementary Medical Insurance (SMI) trust fund is financed through general revenues, premiums and interest income.

In this analysis, years where the assets of the Medicare HI trust fund are increased allow for immediate reductions in current federal general funding obligations for Medicare, as the surplus is recorded as special interest-bearing treasury obligations that are intermingled with all other general revenue. We report these funds as an offset to the difference between program outlays and the dedicated financing sources of Medicare. The dedicated financing sources are HI payroll taxes, the HI share of income taxes on Social Security benefits, beneficiary premiums, and beginning in 2006, Part D state transfers.[11]

The NHEA Medicare 'source of funding' estimates are distributed to reflect these different financing sources. In this analysis, the HI payroll taxes paid by employers, along with one-half of the self-employed payroll taxes, were subtracted from NHEA Medicare estimates and assigned to the business, Federal and state/local government sector in which employers or self-employed individuals operate. The employees' share of HI payroll taxes, together with the other half of the self-employed payroll taxes, HI

[9] The portion of the Federal income tax that people pay on their SSA benefits is allocated to the HI trust fund.

taxation of benefits and SMI premiums was moved to the household section. The Social Security Administration's Office of the Actuary supplied estimates of tax liability for self-employed workers, employees and their employers; estimates of the taxation of benefits and SMI premiums are from the Center for Medicare and Medicaid Services' (CMS) Office of the Actuary.[9] The remaining Medicare Federal government expenditures are roughly equal to trust fund interest income and Federal general revenue contributions to Medicare and are assigned to governments.

Medicare estimates are further adjusted by the removal of Medicaid buy-ins (payments made by state Medicaid programs for Medicare Part A and Part B premiums for eligible individuals) that are then added to state and local government Medicaid spending. The buy-in amounts are estimated from Medicaid financial information reports filed by state Medicaid agencies on Form CMS-64 (http://www.cms.hhs.gov/medicaidbudgetexpendsystem/02_cms64.asp?)

[10] Other revenue includes transfers from the Railroad Retirement Account, health care fraud and abuse control receipts (i.e. civil penalties and damages), general fund reimbursement for transitional uninsured coverage (such as certain Federal employees) and other sources of revenues.

[11] Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicaid Insurance Trust Fund: *The 2005 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal SupplementaryMedical Insurance Trust Fund.* Washington, DC, March 23, 2005,